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Page 4
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1821
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01800

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle MAUDE Last BELL		4. DATE OF DEATH Month FEB Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 18, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BELL		14. MOTHER'S MAIDEN NAME CLARA McAlister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT W.C. Goggin, Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Acute Myocardial Failure DUE TO (b) Chronic Myocardial Disease DUE TO (c) Chronic Cardio-Vascular Renal Failure		INTERVAL BETWEEN ONSET AND DEATH 5 min Some years Some years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 21, 1960 to Feb 16, 1961 , that (I) was last saw the deceased alive on Jan 25, 1961 , and that death occurred at 8:30 AM on the causes and on the date stated above.			
22a. SIGNATURE Vaher M. Seron MD		22b. DATE SIGNED Feb. 16, 1961	
22c. PHYSICIAN'S NAME (Type) VANEH M. SERON MD		22d. ADDRESS Aguasco, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-20-61	
23c. NAME OF CEMETERY OR CREMATORY SCRUB GRASS		23d. LOCATION (City, town, or county) (State) EMLENTON, PENN.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR FEB 20 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1931

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1822

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01801

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. LENGTH OF STAY IN lb 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD H. BOWIE		4. DATE OF DEATH February 4th 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 April 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Bowie		14. MOTHER'S MAIDEN NAME Mollie Sanders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mr.s. Ida Davis - 3327 Roslyn Ave, S.E. Wash,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse DUE TO H2O2O Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 20 min 4 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 4 Feb 19 61 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Wooddy MD M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 Feb 61	
22c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY, MD		22d. ADDRESS JARWOOD CLINIC LAPLATA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/1961	
23c. NAME OF CEMETERY OR CREMATORY Chickamuxen Methodist		23d. LOCATION (City, town, or county) (State) Chickamuxen, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard Funeral Home, Inc. ADDRESS Archart Funeral Home, Inc. La Plata, Md.		25a. REC'D BY REGISTRAR DATE FEB 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1855

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1 1824 CERTIFICATE OF DEATH Reg. Dist. No. 01803

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DONCASTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Doncaster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SALLIE ELIZABETH VIRGINIA DEAKINS		4. DATE OF DEATH FEBRUARY 19 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 March 1870
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At. Home	
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS S. MADDOX		14. MOTHER'S MAIDEN NAME MARY SKINNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Son Kirby Deakins, Doncaster Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerosis DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1955 to 19 Feb 1961 , that I last saw the deceased alive on 19 February, 1961 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) JARWOOD CLINIC DATE SIGNED 19 Feb 61			
ACTUAL SIGNATURE Arthur O. Woody M.D.		PHYSICIAN'S NAME (Type) ARTHUR O. WOODY LA PLATA, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/1961	22c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist Cemetery	22d. LOCATION (City, town, or county) (State) Nanjemoy, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. ADDRESS La Plata, Md.		24a. REC'D BY REGISTRAR FEB 28 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL BY ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1825

CERTIFICATE OF DEATH

Reg. Dist. No. 01804

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Welcome</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Welcome</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last <u>DEVLIN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-11</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VICTOR S. SEWARD</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE DAWSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FRANCIS DEVLIN</u> Address <u>Welcome Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IC CONGESTIVE HEART FAILURE</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>1926</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-2-61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-26</u> , 19 <u>60</u> , to <u>2-2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1-29</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		ADDRESS (Street, city or town, State) <u>2411 Latrobe</u> DATE SIGNED <u>2-2-61</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-7-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia Penn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grechert Inc.</u> ADDRESS <u>Caplata Md</u>		24a. REC'D BY REGISTRAR <u>FEB 8 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	
<p>15. SIGNATURE OF DECEASED [Faint text]</p>		<p>16. SIGNATURE OF DECEASED [Faint text]</p>	
<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF DECEASED [Faint text]</p>	
<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF DECEASED [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF DECEASED [Faint text]</p>	
<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF DECEASED [Faint text]</p>	
<p>25. SIGNATURE OF DECEASED [Faint text]</p>		<p>26. SIGNATURE OF DECEASED [Faint text]</p>	
<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF DECEASED [Faint text]</p>	
<p>29. SIGNATURE OF DECEASED [Faint text]</p>		<p>30. SIGNATURE OF DECEASED [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF DECEASED [Faint text]</p>	
<p>33. SIGNATURE OF DECEASED [Faint text]</p>		<p>34. SIGNATURE OF DECEASED [Faint text]</p>	
<p>35. SIGNATURE OF DECEASED [Faint text]</p>		<p>36. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF DECEASED [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF DECEASED [Faint text]</p>	
<p>45. SIGNATURE OF DECEASED [Faint text]</p>		<p>46. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF DECEASED [Faint text]</p>	
<p>63. SIGNATURE OF DECEASED [Faint text]</p>		<p>64. SIGNATURE OF DECEASED [Faint text]</p>	
<p>65. SIGNATURE OF DECEASED [Faint text]</p>		<p>66. SIGNATURE OF DECEASED [Faint text]</p>	
<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF DECEASED [Faint text]</p>	
<p>69. SIGNATURE OF DECEASED [Faint text]</p>		<p>70. SIGNATURE OF DECEASED [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF DECEASED [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF DECEASED [Faint text]</p>	
<p>75. SIGNATURE OF DECEASED [Faint text]</p>		<p>76. SIGNATURE OF DECEASED [Faint text]</p>	
<p>77. SIGNATURE OF DECEASED [Faint text]</p>		<p>78. SIGNATURE OF DECEASED [Faint text]</p>	
<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF DECEASED [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF DECEASED [Faint text]</p>	
<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF DECEASED [Faint text]</p>	
<p>85. SIGNATURE OF DECEASED [Faint text]</p>		<p>86. SIGNATURE OF DECEASED [Faint text]</p>	
<p>87. SIGNATURE OF DECEASED [Faint text]</p>		<p>88. SIGNATURE OF DECEASED [Faint text]</p>	
<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF DECEASED [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF DECEASED [Faint text]</p>	
<p>93. SIGNATURE OF DECEASED [Faint text]</p>		<p>94. SIGNATURE OF DECEASED [Faint text]</p>	
<p>95. SIGNATURE OF DECEASED [Faint text]</p>		<p>96. SIGNATURE OF DECEASED [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF DECEASED [Faint text]</p>	
<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF DECEASED [Faint text]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1826
CERTIFICATE OF DEATH

Reg. Dist. No. **01805**

1. PLACE OF DEATH o. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Cecil GARDINER				4. DATE OF DEATH Month Day Year 2 24 1961			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-1878	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Richard Gardiner				14. MOTHER'S MAIDEN NAME Lucy Ann Higdon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hugh Gardiner Jr., Faulkner, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GEN. ART Sclerosis (c) 2 yrs</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 2-24-61</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-22-1961 to 2-24-1961 , that I last saw the deceased alive on 2-24-1961 , and that death occurred on 2-24-1961 , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				DATE SIGNED 2-24-61			
PHYSICIAN'S NAME (Type) E. J. EDLEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-61		22c. NAME OF CEMETERY OR CREMATORY St Peters		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funerals/ Home Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAR 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

5281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1828

Item 9 Film G281 2/23/61 mb

CERTIFICATE OF DEATH

Reg. Dist. No.

01807

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gradyton</u>		c. LENGTH OF STAY IN 1b <u>67 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gradyton</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Ann Henson</u>		4. DATE OF DEATH <u>February 8 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1894</u>
		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Gradyton Md</u>
		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wesley Henson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bonister</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year of dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Rosie Henson (Daughter)</u> Address <u>Gradyton Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-Enteritis, acute (2 day duration)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/31 1957</u> to <u>2/8 1961</u> , that I last saw the deceased alive on <u>2/7 1961</u> , and that death occurred at <u>HP</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>2-9-61</u>	
PHYSICIAN'S NAME (Type) <u>Frank A Susan M.D.</u>		<u>Indian Head Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Gradyton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins</u> ADDRESS <u>4804 Ga Ave NW</u>		24a. REC'D BY REGISTRAR <u>FEB 14 '61</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1829

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES M. JONES		45		Male		White		1829	
PLACE OF DEATH		RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
At home		At home		Farmer		Died of natural causes		Natural	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF MINISTER		NAME OF FUNERAL HOME		NAME OF CEMETERY	
1829		At home		Rev. J. M. Jones		J. M. Jones & Co.		St. John's Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	
James M. Jones		John M. Jones		Rev. J. M. Jones		J. M. Jones & Co.		St. John's Cemetery	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		NAME OF REGISTRAR		NAME OF CLERK		NAME OF ASSISTANT CLERK	
1829		At home		J. M. Jones		J. M. Jones		J. M. Jones	

CERTIFICATE OF DEATH

Reg. Dist. No. 01809

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Richard Last Lomax		4. DATE OF DEATH Month Feb. Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Lomax		14. MOTHER'S MAIDEN NAME Alice Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Effie Lomax - Bel Alton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio -Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-6-'61 1955	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-25 , 19 61 , to 2-6 , 19 61 , that I last saw the deceased alive on 2-5 , 19 61 , and that death occurred at 10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 2-8-'61			
ACTUAL SIGNATURE E. J. Edelen		M.D. E. J. Edelen	
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.		La Plata, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1961	
22c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery		22d. LOCATION (City, town, or county) (State) Newport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard L. Lomax, Inc.		24a. REC'D BY REGISTRAR Feb 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Lomax			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

С. И. О. К.

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10

15
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01811	
1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Hudson</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bayonne</u> <u>67X-3</u> d. STREET ADDRESS <u>1360 Broadway</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILMORF</u> c. LENGTH OF STAY in 1b <u>Trans</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
3. NAME OF DECEASED (Type or print) <u>MAYOR</u> First Middle Last <u>SINGER</u>					4. DATE OF DEATH Month Day Year <u>2 15 1961</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>			11. BIRTHPLACE (State or foreign country) <u>Romania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachary Singer</u>					14. MOTHER'S MAIDEN NAME <u>Hannah</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>						
17. INFORMANT <u>Louis Singer</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY to chest</u> DUE TO <u>Heart & ARYS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>RUN OVER BY TRAILER TRUCK</u> DUE TO <u>2-15-61</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>WALKING ON HWAY - RUN OVER BY TRAILER TRUCK</u>						
20c. TIME OF INJURY Month, Day, Year <u>4 30 2-15-1961</u>					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>301 Hwy</u>					20f. (City or town) <u>Weymouth</u> (County) <u>Chase Hill</u> (State) <u>N.J.</u>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. J. EDEN</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>E. J. EDEN</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					Address (Street, city, town, or county) <u>2-15-61</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3-16-61</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Cemetery</u>			22d. LOCATION (City, town, or county) <u>Newark, New Jersey</u> (State)		
23. FUNERAL DIRECTOR <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>					24a. REC'D BY REGISTRAR <u>FEB 20 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>						

MEDICAL CERTIFICATION

1873 MEDICAL EXAMINER CERTIFICATE OF DEATH

THE STATE
HEALTH DEPT.

(M)

(1)

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01812

1833

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Ches</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <i>JOHN</i> First <i>N R DEBICK</i> Middle <i>SLATER</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-60</i>
9. AGE (In years last birthday) <i>1</i> yrs. <i>12</i> mos. <i>3</i> days		IF UNDER 1 YEAR	IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>John S. Slater Jr.</i>	14. MOTHER'S MAIDEN NAME <i>May A. Green Sandidgh</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year no. or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>John S. Slater Jr.</i> Address <i>—</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA</i> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>—</i> (c) <i>—</i> DUE TO (a) stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>1-24-61</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <i>E. J. EDELEN</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>2-1-61</i>
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/2/1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glennant Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Marbury, Maryland</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Archant Funeral Home, La Plata, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>—</i>	24b. REGISTRAR'S SIGNATURE <i>Christen S. Frank</i>
		DATE <i>FEB 8 '61</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, indicating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 1834 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01813

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplata Md		c. LENGTH OF STAY IN 1b 9-Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial Hosp. Laplata Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph S. Snell		4. DATE OF DEATH 2-8-61	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 7 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-US-Govt.		10b. KIND OF BUSINESS OR INDUSTRY US-Govt.	
11. BIRTHPLACE (State or foreign country) Dayton-Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Snell		14. MOTHER'S MAIDEN NAME Melinda Steinspring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-34-7679	
17. INFORMANT Margeret Snell-(wife)		Address 42-Greenwood Indian Head Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesentery Thrombosis 5 71.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal Virus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24-Hrs 9-Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Transmural Posterior Wall Myocardial Infarction with Partial AV Block		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-30-61 , 19 61 , to 2-8-61 , 19 61 , that I last saw the deceased alive on 2-8-61 , 19 61 , and that death occurred at 3-50P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Indian Head Md DATE SIGNED 2-9-61			
ACTUAL SIGNATURE James E. Andrews		PHYSICIAN'S NAME (Type) James E. Andrews	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-11-61	
22c. NAME OF CEMETERY OR CREMATORY Trinity Memorial		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR FEB 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1835

CERTIFICATE OF DEATH

Reg. Dist. No. 01814

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Eleanor Strobel		4. DATE OF DEATH Month Day Year February 4 1961 19	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8 1922
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St, Marys Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Glenn Wallace		14. MOTHER'S MAIDEN NAME Mary Newton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Strobel, Waldorf, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 670X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2-4-61 2-4-61 8/2-61	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4-61, to 2-4-61, that I last saw the deceased alive on 2-4-61, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Edelen M.D.		DATE SIGNED 2-6-61	
PHYSICIAN'S NAME (Type) Edward J. Edelen MD		La Plata, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Feb. 8 1961	22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '61	
24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1835

<p>1. Name of deceased (Print name in full) _____</p>		<p>2. Sex _____</p>		<p>3. Age _____</p>	
<p>4. Date of death _____</p>		<p>5. Time of death _____</p>		<p>6. Place of death _____</p>	
<p>7. Cause of death (State immediately and briefly) _____</p>		<p>8. Nature of disease (State fully) _____</p>		<p>9. Duration of disease (State fully) _____</p>	
<p>10. Name of physician (Print name in full) _____</p>		<p>11. Name of attending physician (Print name in full) _____</p>		<p>12. Name of coroner (Print name in full) _____</p>	
<p>13. Name of registrar (Print name in full) _____</p>		<p>14. Name of informant (Print name in full) _____</p>		<p>15. Name of witness (Print name in full) _____</p>	
<p>16. Name of funeral home (Print name in full) _____</p>		<p>17. Name of cemetery (Print name in full) _____</p>		<p>18. Name of burial place (Print name in full) _____</p>	
<p>19. Name of interment place (Print name in full) _____</p>		<p>20. Name of burial place (Print name in full) _____</p>		<p>21. Name of burial place (Print name in full) _____</p>	
<p>22. Name of burial place (Print name in full) _____</p>		<p>23. Name of burial place (Print name in full) _____</p>		<p>24. Name of burial place (Print name in full) _____</p>	
<p>25. Name of burial place (Print name in full) _____</p>		<p>26. Name of burial place (Print name in full) _____</p>		<p>27. Name of burial place (Print name in full) _____</p>	
<p>28. Name of burial place (Print name in full) _____</p>		<p>29. Name of burial place (Print name in full) _____</p>		<p>30. Name of burial place (Print name in full) _____</p>	
<p>31. Name of burial place (Print name in full) _____</p>		<p>32. Name of burial place (Print name in full) _____</p>		<p>33. Name of burial place (Print name in full) _____</p>	
<p>34. Name of burial place (Print name in full) _____</p>		<p>35. Name of burial place (Print name in full) _____</p>		<p>36. Name of burial place (Print name in full) _____</p>	
<p>37. Name of burial place (Print name in full) _____</p>		<p>38. Name of burial place (Print name in full) _____</p>		<p>39. Name of burial place (Print name in full) _____</p>	
<p>40. Name of burial place (Print name in full) _____</p>		<p>41. Name of burial place (Print name in full) _____</p>		<p>42. Name of burial place (Print name in full) _____</p>	
<p>43. Name of burial place (Print name in full) _____</p>		<p>44. Name of burial place (Print name in full) _____</p>		<p>45. Name of burial place (Print name in full) _____</p>	
<p>46. Name of burial place (Print name in full) _____</p>		<p>47. Name of burial place (Print name in full) _____</p>		<p>48. Name of burial place (Print name in full) _____</p>	
<p>49. Name of burial place (Print name in full) _____</p>		<p>50. Name of burial place (Print name in full) _____</p>		<p>51. Name of burial place (Print name in full) _____</p>	
<p>52. Name of burial place (Print name in full) _____</p>		<p>53. Name of burial place (Print name in full) _____</p>		<p>54. Name of burial place (Print name in full) _____</p>	
<p>55. Name of burial place (Print name in full) _____</p>		<p>56. Name of burial place (Print name in full) _____</p>		<p>57. Name of burial place (Print name in full) _____</p>	
<p>58. Name of burial place (Print name in full) _____</p>		<p>59. Name of burial place (Print name in full) _____</p>		<p>60. Name of burial place (Print name in full) _____</p>	
<p>61. Name of burial place (Print name in full) _____</p>		<p>62. Name of burial place (Print name in full) _____</p>		<p>63. Name of burial place (Print name in full) _____</p>	
<p>64. Name of burial place (Print name in full) _____</p>		<p>65. Name of burial place (Print name in full) _____</p>		<p>66. Name of burial place (Print name in full) _____</p>	
<p>67. Name of burial place (Print name in full) _____</p>		<p>68. Name of burial place (Print name in full) _____</p>		<p>69. Name of burial place (Print name in full) _____</p>	
<p>70. Name of burial place (Print name in full) _____</p>		<p>71. Name of burial place (Print name in full) _____</p>		<p>72. Name of burial place (Print name in full) _____</p>	
<p>73. Name of burial place (Print name in full) _____</p>		<p>74. Name of burial place (Print name in full) _____</p>		<p>75. Name of burial place (Print name in full) _____</p>	
<p>76. Name of burial place (Print name in full) _____</p>		<p>77. Name of burial place (Print name in full) _____</p>		<p>78. Name of burial place (Print name in full) _____</p>	
<p>79. Name of burial place (Print name in full) _____</p>		<p>80. Name of burial place (Print name in full) _____</p>		<p>81. Name of burial place (Print name in full) _____</p>	
<p>82. Name of burial place (Print name in full) _____</p>		<p>83. Name of burial place (Print name in full) _____</p>		<p>84. Name of burial place (Print name in full) _____</p>	
<p>85. Name of burial place (Print name in full) _____</p>		<p>86. Name of burial place (Print name in full) _____</p>		<p>87. Name of burial place (Print name in full) _____</p>	
<p>88. Name of burial place (Print name in full) _____</p>		<p>89. Name of burial place (Print name in full) _____</p>		<p>90. Name of burial place (Print name in full) _____</p>	
<p>91. Name of burial place (Print name in full) _____</p>		<p>92. Name of burial place (Print name in full) _____</p>		<p>93. Name of burial place (Print name in full) _____</p>	
<p>94. Name of burial place (Print name in full) _____</p>		<p>95. Name of burial place (Print name in full) _____</p>		<p>96. Name of burial place (Print name in full) _____</p>	
<p>97. Name of burial place (Print name in full) _____</p>		<p>98. Name of burial place (Print name in full) _____</p>		<p>99. Name of burial place (Print name in full) _____</p>	
<p>100. Name of burial place (Print name in full) _____</p>		<p>101. Name of burial place (Print name in full) _____</p>		<p>102. Name of burial place (Print name in full) _____</p>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is pending, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01815

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) D.O.A. La Plata c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rison d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle WILBUR Last TURNER			4. DATE OF DEATH Month February Day 17 Year 19 61				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 2, 1901	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 5 Days 17 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY On Farm		11. BIRTHPLACE (State or foreign country) Charles County, Md.			
13. FATHER'S NAME John T. Turner			14. MOTHER'S MAIDEN NAME Mary M. Hardesty				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-14-4698		17. INFORMANT Mr. Aubrey Bowie-Rison, Maryland (Brother)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Consecutive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular Disease (c) Disease				INTERVAL BETWEEN ONSET AND DEATH 1954			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: (Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 248-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/1961		22c. NAME OF CEMETERY OR CREMATORY Chicamuxen Methodist Cemetery			
22d. LOCATION (City, town, or country) Chicamuxen, Maryland		22e. NAME OF CEMETERY OR CREMATORY Chicamuxen, Maryland					
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR FEB 28 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL CERTIFICATION

1838

WISCONSIN STATE DEPARTMENT OF HEALTH
VITAL RECORDS SECTION
DEATH CERTIFICATE

0121

WISCONSIN STATE DEPARTMENT OF HEALTH
VITAL RECORDS SECTION
DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG281 2-14-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01816

1837

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp. LaPlata Md		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Richard Leonard Wright First Middle Last		4. DATE OF DEATH 2-3-61 Month Day Year	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt.		10b. KIND OF BUSINESS OR INDUSTRY US-Government	
11. BIRTHPLACE (State or foreign country) Marbury, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Wright		14. MOTHER'S MAIDEN NAME Mary Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wilson Wright, (Son)		Address Accokeek Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage-Left Side 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerosis-General DUE TO (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 6-Days Indefinite Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-1-60 , 19____, to 2-3-61 , 19____, that I last saw the deceased alive on 2-3-61 , 19____, and that death occurred at 5-25AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Indian Head Md DATE SIGNED 2-3-61			
ACTUAL SIGNATURE James E. Andrews MD		PHYSICIAN'S NAME (Type) James E. Andrews MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-61	22c. NAME OF CEMETERY OR CREMATORY Park Hill	22d. LOCATION (City, town, or county) (State) Marbury Md
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf Md		24a. REC'D BY REGISTRAR FEB 7 1961	24b. REGISTRAR'S SIGNATURE Arthur L. Brown

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4: may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1883

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. SMITH		45		M		W		JAN 15 1883		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
1234 N. MAIN ST.		LABORER		HEART DISEASE		NATURAL		J. M. SMITH		J. M. SMITH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS DEATH	
JAN 1 1838		BALTIMORE, MD.		COMMON SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
JAN 15 1883		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. M. SMITH		J. M. SMITH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS DEATH	
JAN 1 1838		BALTIMORE, MD.		COMMON SCHOOL		MARRIED		NONE		NONE	